Appendix 25
Preadmission Screen/Annual Resident Review
Level I Screen

Division of Health
DOH-2191 (Rev. 6/94)

Bureau of Quality Compliance

PREADMISSION SCREEN/ANNUAL RESIDENT REVIEW (PASARR)
LEVEL I SCREEN

This form is required under sections 42 USC 1936r(b)(3)(F) and 1396r(e)(7) [note: these sections also are referred to as 1919(b)(3)(F) and 1919(e)(7) of the Social Security Act].

PLEASE NOTE

Under these sections, Medicaid certified nursing facilities MUST NOT admit any new resident who is suspected of having a serious mental illness or a developmental disability unless the State mental health authority/State developmental disability authority or designee has evaluated the person and determined if the person needs nursing facility placement and if the person needs specialized services.

Additionally, the Level II evaluations and determinations must be repeated each year for each resident who is suspected of having a serious mental illness or a developmental disability. If a nursing facility admits a resident without completion of the appropriate screen(s), then the facility is in violation of the statutory requirement, which may result in initiation of termination action against the facility.

If a Level II screen is required, then information on this (Level I) form is matched with information from the person's Level II screen to ensure that the facility, the Department's designee and the Department have complied with all applicable federal statutes and regulations. Information on this form will be used for no other purpose.

42 CFR 483.128(a) requires that the resident or his/her legal representative receive a written notice (copy of this front page) if the resident is suspected of having a serious mental illness or a developmental disability.

RESIDENT NAME	DATE OF BIRTH

RESIDENT'S ADDRESS (for preadmission screens only)

NURSING FACILITY	FACILITY ADDRESS

GUARDIAN'S NAME (if applicable)

GUARDIAN'S ADDRESS

GUARDIAN'S TELEPHONE #

(HOME) (WORK)

CHECK ONE:

- ☐ The resident is not suspected of having a serious mental illness or a developmental disability.
- ☐ The resident is suspected of having (check the appropriate box below and forward a copy of this Level I screen to the regional screening agency):
  - ☐ A serious mental illness;
  - ☐ A developmental disability; or
  - ☐ Both a serious mental illness and a developmental disability.

STAFF MEMBER COMPLETING THIS SCREEN (sign after completing pages 1 - 4)		TITLE
TELEPHONE	**DATE SCREEN COMPLETED**	**DATE REFERRED TO SCREENING AGENCY**

INSTRUCTIONS

Federal law requires that all individuals requesting admission to a nursing facility must be screened to determine the presence of a major mental illness and/or a developmental disability. **42 CFR 483.75(l)(5) requires the nursing facility to keep a copy of this form and the results of other preadmission screening(s) in the resident's clinical record.**

Please complete this form by checking the boxes in Sections A, B and C and follow the instructions at the end of each section. Be sure to sign and date the form on the bottom of the front page when you are finished.

PREADMISSION: All individuals seeking admission to a nursing facility must receive a Level I Screen prior to admission.

READMISSION: Individuals who are being readmitted to a Medicaid certified nursing facility after a hospital stay of any type or of any length may be readmitted without completion of another Level I or Level II Screen.

INTERFACILITY TRANSFERS: Residents who are transferred from one nursing facility to another, with or without an intervening hospital stay, are not subject to another Level I or Level II Screen. However, the transferring nursing facility is responsible for ensuring that any PASARR screening reports accompany the transferring resident, and for notifying the Area Screening Agency so that the resident's new location is known for future annual resident reviews.

CHANGE IN STATUS: For those individuals presently residing in a nursing home, this form should be filled out only if there is a change of status in Sections A or B.

SECTION A

QUESTIONS REGARDING MENTAL ILLNESS	YES	NO
1. **CURRENT DIAGNOSIS** Is the individual currently diagnosed as having a major mental illness (such as schizophrenia, paranoia, mood disorder, schizoaffective disorder or atypical psychosis) OR other DSM-IV psychiatric disorder that causes severe functional impairment which precludes independent functioning?		
2. **MEDICATIONS** Within the past six months, has this person been prescribed on a regular basis a major tranquilizer and/or anti-psychotic medication for a major mental health condition when there is no existing organic disorder? If the answer is no, see the note below. If yes, check the YES box to the right and check all prescribed medication(s) on the following list:		

☐ Amitriptyline & Perphenazine /Triavil	☐ Doxepin/Sinequan	☐ Perphenazine/Trilafon
☐ Amitriptyline/Elavil	☐ Fluoxetine/Prozac	☐ Phenelzine/Nardil
☐ Amoxapine/Ascendin	☐ Fluphenazine-Decanoate/Prolixin	☐ Protriptyline/Vivactil
☐ Bupropion/Wellbutrin	☐ Haloperidol/Haldol	☐ Sertraline/Zoloft
☐ Carbamazepine/Tegretol	☐ Imipramine/Tofranil	☐ Thioridazine/Mellaril
☐ Chlorpromazine/Thorazine	☐ Isocarboxazid/Marplan	☐ Thiothixene/Navane
☐ Chlorprothixene/Taractan	☐ Lithium/Lithobid	☐ Tranylcypromine/Parnate
☐ Clomipramine/Anafranil	☐ Loxapine/Loxitane	☐ Trazadone/Desyrel
☐ Clonazepam/Klonopin	☐ Maprotiline/Ludiomil	☐ Trifluoperazine/Stelazine
☐ Clozapine/Clozaril	☐ Mesoridazine/Serentil	☐ Trimipramine/Surmontil
☐ Desipramine/Norpramin	☐ Molindone/Moban	☐ Valproic Acid/Depakene
	☐ Nortriptyline/Pamelor or Aventyl	☐ Other

NOTE: If no major mental illness exists, but one of the above Medications is prescribed, check the "NO" box above and place a notation from the physician in the record identifying the medication and the symptoms and behaviors for which it is prescribed. Note on this form where this information can be found (e.g., see physician's progress note dated 1/1/94).

QUESTIONS REGARDING MENTAL ILLNESS (continued)	YES	NO
3. **SYMPTOMATOLOGY** Is there any presenting manifestation of mental illness, not related to an organic condition, such as: a. Suicidal statements, gestures, or acts?		
b. Hallucinations, delusions, or other psychotic symptoms that pose a serious threat to the safety of the individual or others?		
c. Severe and extraordinary thought or mood disorders that pose a serious threat to the safety of the individual or others?		
QUESTIONS REGARDING DEVELOPMENTAL DISABILITIES	**YES**	**NO**
4. Is there a diagnosis of mental retardation or developmental disability in the individual's past?		
5. Is there any history of mental retardation or developmental disability in the individual's past?		
6. Is there any apparent presenting manifestation (cognitive or behavioral) that may indicate the person has mental retardation or developmental disability?		
NOTE: Wisconsin nursing home rules [HSS-132.51(2)(d)] require that no person who has a developmental disability may be admitted to a nursing facility unless the person requires skilled nursing facility (SNF) services.		

If you have answered no to all the above questions in Section A, the individual does not require further PASARR evaluation. Sign this form and place in the individual's chart. No further action needs to be taken. If you have answered yes to any of the questions, proceed to Section B.

SECTION B

QUESTIONS REGARDING LENGTH OF STAY	YES	NO
The following situations, which are all for short-term admissions, are the only exemptions from Level II Screening.		
1. **HOSPITAL DISCHARGE EXEMPTION - 30 DAY MAXIMUM** Is this individual entering the nursing facility from a hospital (not a psychiatric unit) for the purpose of convalescing from a medical problem for 30 days or less.		
2. **PENDING ALTERNATE PLACEMENT - 30 DAY MAXIMUM** Is this individual entering the nursing facility for a short term stay of 30 days or less while an appropriate placement is located? This individual may be entering the nursing facility from any setting.		
3. **EMERGENCY PLACEMENT - 7 DAY MAXIMUM** Is this individual entering the nursing facility for further assessment in an emergency situation requiring protective services?		
4. **RESPITE CARE - 30 DAYS PER YEAR MAXIMUM** Is this individual entering the nursing facility to provide respite to in-home caregivers to whom the individual is expected to return following a brief nursing facility stay?		

If you have answered yes to any of the items in Section B, the individual may enter the nursing facility with county approval, through the DCS-822 form, for the specified period of time without a referral for a PASARR Level II Screen. Contact the Area Screening Agency to notify them that the person is being admitted and qualifies for an exemption in Section B and forward a copy of the Level I Screen to the Area Screening Agency. If, during the short term stay, it is established that the individual will be staying for a longer period of time than permitted above, the individual must be referred for a Level II Screen.

An individual who entered the facility under the 30-day hospital discharge exemption or pending alternate placement exemption, who is later found to require more than 30 days of nursing facility care must have a Level II Screen Annual Resident Review within 40 calendar days of admission. In those cases the nursing facility must contact the Area Screening Agency so that the Level II Screen can be completed within that time frame.

If you have answered no to the questions in Section B, proceed to Section C.

SECTION C

QUESTIONS REGARDING SEVERE MEDICAL CONDITION	YES	NO
The following questions regarding severe medical condition in conjunction with a major mental illness or developmental disability may indicate that the individual meets the criteria for a categorical determination that specialized services are not required. This information may form the basis for an abbreviated screen.		
1. **TERMINAL ILLNESS** Is this individual terminally ill? (Expected to expire within six months.)		
2. **SEVERE MEDICAL CONDITION**		
Is the individual comatose?		
Is the individual ventilator dependent?		
Is the individual functioning at a brain-stem level?		
Does the individual have a severe medical illness, such as Chronic Obstructive Pulmonary Disease, Parkinson's Disease, Huntington's Disease, Amyotrophic Lateral Sclerosis or Congestive Heart Failure, which result in a level of impairment so severe that the individual could not participate in or benefit from specialized services?		
3. **SEVERE DEMENTIA (including Alzheimer's disease or a related disorder)** Does the individual have a primary diagnosis that results in a level of impairment so severe that the individual could not be expected to participate in or benefit from specialized services? Note: Person's record must show evidence that supports a dementia diagnosis. If Organic Brain Syndrome (OBS) is used as an exemption, it must refer to a primary diagnosis of dementia.		

If you have answered yes to any of the questions in this section, you are required to send to the screening agency, the Level I screen along with available documentation such as tests and other evaluations to verify the condition and the severity of impact the medical condition has on the individual's independent functioning. The screening agency will determine whether the individual meets the criteria for a categorical determination or if a full Level II Screen is warranted. If you have answered no to the questions in this section, proceed to Section D.

SECTION D

REFERRING A PERSON TO THE REGIONAL SCREENING AGENCY

If you have answered "no" to all of the questions in Section A, no further PASARR screening is needed. Complete the signature section on page 1 and retain a copy of this form in the resident's nursing facility medical record.

If you have answered "yes" to any question in Section A and "no" to all of the exemptions listed in Sections B and C, follow these instructions:

- Contact the Area Screening Agency to notify them that the person is being considered for admission and forward a copy of the Level I screen to the Area Screening Agency (a copy must also be maintained in the nursing facility file).
- The Area Screening Agency will perform a Level II Screen for persons with developmental disabilities and/or mental illnesses (regardless of age) and a determination will be made as to whether or not the person needs facility care and if specialized services are required.
- The screening agency will notify the nursing facility and the resident or his/her legal representative, in writing of the determinations made.